Project Summary

NATIONAL ASSOCIATION OF
Community Health Centers®

Project Summary

Approximately 9% of Community Health Center patients, or 2.8 million, are living with diabetes[1]. Additionally, according to the Centers for Disease Control and Prevention (CDC), approximately 96 million American adults, or more than 1 in 3, are living with prediabetes[2]. Of those with prediabetes, more than 80% don't know they have it, and formal screening for diabetes risk is not consistently provided to patients in health care settings. A significant portion of health centers' patients include individuals living with diabetes or at risk for diabetes.

35.6%
of Community Health Center patients are living with diabetes.

1 in 3
American adults are living with prediabetes.

>80%
of those with prediabetes don't know they have it.

The National Association of Community Health Centers (NACHC) recognizes that the prevalence of this condition has reached epidemic proportions and requires immediate solutions to better prevent and manage.

Healthy Together is a lifestyle change program launched by NACHC's Quality Center and supported by the Health Resources and Services Administration (HRSA) that blends technology, at-home self-care tools, lifestyle coaching, and ongoing support with trained health center staff and their network of partners to increase the impact of diabetes prevention and management at health centers. Guided by NACHC's Value Transformation Framework, which enhances health center infrastructure, care delivery, and people systems to tackle issues such as diabetes, NACHC's Quality Center used a systems approach when designing *Healthy Together*. The goal is to improve health outcomes, patient and staff experience, cost, and equity (the Quintuple Aim goals).

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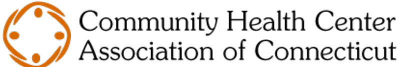
Healthy Together engaged partnerships at the national, state/network, and local levels, including:

THE ASSOCIATION OF DIABETES CARE & EDUCATION SPECIALISTS (ADCES)
The National Lifestyle Coach partner who trained health center staff in Lifestyle Coaching, and who assisted the local level health center Lifestyle Coaches with curriculum content delivery.

THREE STATE/REGIONAL PRIMARY CARE ASSOCIATIONS (PCAS) OR HEALTH CENTER CONTROLLED NETWORKS (HCCN's) referred to as 'Hubs', were essential partners in providing their participating health centers with programmatic guidance, technical assistance, and data collection assurance:



A COHORT OF HEALTH CENTERS who participated in NACHC's diabetes learning collaborative and continued engagement as participants in the *Healthy Together* program:

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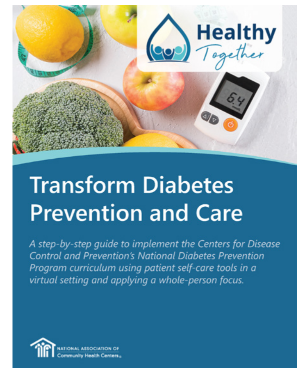
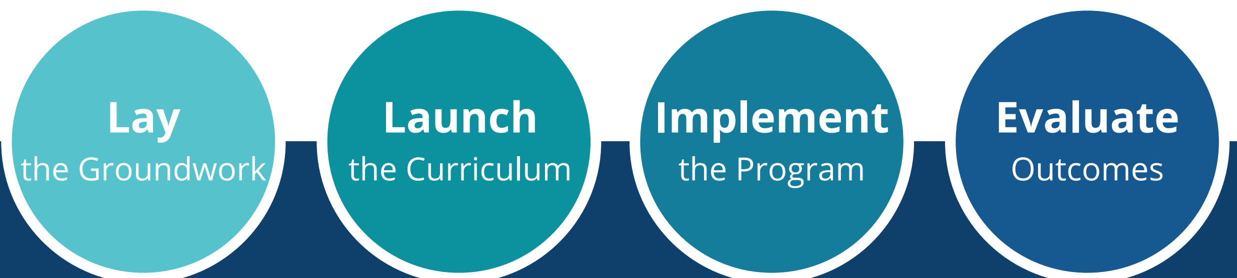
Healthy Together uniquely expands the CDC-approved curriculum for a National Diabetes Prevention Program (NDPP) for people with diabetes, as well as those at risk for diabetes, and breaks barriers by building patient self-management skills in healthy eating, physical activity, and stress management through lifestyle coaching within a group setting. This model is culturally inclusive and applies a whole-person/family-centered approach, encouraging members of the same family/household to participate together. Most importantly, it empowers participants by providing them with self-care tools and the knowledge to implement healthy lifestyle changes that may last a lifetime.

Healthy Together also expands the skillset of health center staff and partners through professional development training in Lifestyle Coaching. These skills are highly relevant and valuable even beyond the project's scope. Trained health center Lifestyle Coaches teach patients ways to implement healthy lifestyle changes, such as how to prevent or manage diabetes, use self-care tools, and ways to track their progress. Coaches also screen for social risk factors and connect patients with services or programs to address social needs.



From July 2021 through December 2021, NACHC designed the Healthy Together program, built a robust program infrastructure, and worked collaboratively with key partners. Additionally, NACHC created a step-by-step Action Guide as a roadmap for health centers to implement the Healthy Together program. This Action Guide outlines health center action steps organized into four operational phases: Laying the Groundwork, Launching the Curriculum, Implementing the Program, and Evaluating the Outcomes.

Healthy Together Program Implementation Phases



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Lay
the Groundwork

PHASE 1

The '**Lay the Groundwork**' phase proved to be instrumental in enabling health centers to build the foundation needed for the program. Participating health centers selected the staff who would serve on their project team, including those trained to serve as Lifestyle Coaches. NACHC facilitated monthly project calls, offering health center project teams and Hubs coaching, peer connection opportunities, information sharing, and training. Health center project leads were provided access to the Healthy Together Online Learning Community located with NACHC's Elevate Online Learning Platform. This online learning community supplies information and resources to all participating health centers. To support a team-based approach to care, participating health center leadership announced their support for the Healthy Together project to their respective health center staff.

With the support of their Hubs, the health center project teams soon turned their attention to identifying health center patients with type 2 diabetes and patients at risk for type 2 diabetes who meet program eligibility. Health centers generated patient lists and identified 'Provider Champions' – providers who are enthusiastic about the project and willing to help refer and engage their eligible patients. Risk stratification methods were employed to identify patients who may benefit the most from the program. Health centers recognized that a team-based staffing model, including the Healthy Together team and referring provider/s, was more effective than a single member as those health centers faced more patient recruitment and retention challenges.

Healthy Together workflows and processes for managing patient self-care tools were developed and documented in flow charts so that other health center staff and project partners could readily visualize the steps. The patient educational materials offered a unique opportunity to place tools and information into the hands of patients. With proper support and training, this can improve care and health outcomes. Health centers provided ongoing patient education and support during the program year to motivate participants and encourage active engagement.

In addition to the overarching *Healthy Together* project goals, each health center defined success for the program at the local level. With the support of their Hubs, health center project teams developed a set of organizational goals. Lifestyle Coaches also developed individual lifestyle change goals together with each participant.

Health center staff selected to serve as Lifestyle Coaches were trained by the Association for Diabetes Care and Education Specialists (ADCES), nationally recognized experts in diabetes prevention and control. Lifestyle Coach training took place in a series of five 90-minute sessions, conducted once/week over five weeks. It covered the NationalDPP curriculum content, how to facilitate group discussions, and how to build patient self-management skills. Feedback from those who attended the Lifestyle Coach training was that the concepts learned would be helpful outside of project work and could be widely applied across all patients. Additional training offered instruction on data collection, following CDC's National DPP specifications, as well as instructions for Lifestyle Coaches to launch a virtual curriculum session.

Health centers individually set their curriculum session schedules to best meet the needs of the participants and the Lifestyle Coaches. Schedules include in-person and virtual sessions to optimize the ability to provide at-home care and face-to-face touchpoints throughout the program. Recruitment and retention have been the most challenging aspects of the project to date. The yearlong commitment, and the fixed schedule of curriculum sessions can deter patients from becoming involved, even if they recognize that they could benefit from lifestyle changes and coaching.

Launch the Curriculum

PHASE 2

In the 'Launch' phase of Healthy Together, each confirmed participant was scheduled for an individual in-person 'Start-Up Visit'. During the Start-Up Visits, participants signed a participation agreement. Lifestyle Coaches assisted participants with the technology utilized for the program, and completed a pre-program social risk questionnaire. Additionally, patients received their initial set of patient tools and training on using each item in the kit.

Implement the Program

PHASE 3

During the '**Implement**' phase, the group sessions of CDC's NDPP curriculum began. Healthy Together followed the CDC NDPP requirement that the program run for one year, divided into two phases: the Core Phase and the Core Maintenance Phase. The health center Lifestyle Coaches delivered curriculum content to participants with specific attention to the local and cultural needs while the ADCES expert provided supporting content accessible via a recorded video. Health centers varied in their use of the ADCES videos; while some Coaches preferred to teach the curriculum content themselves and use the videos only as a tool to aid in their preparation for the session, others preferred to share the videos with the participants.

Evaluate Outcomes

PHASE 4

In the 'Evaluate' phase of the program, health centers have established an ongoing process for Lifestyle Coaches to collect the data elements required by the CDC's National DPP – including data related to engagement in curriculum sessions and progress in meeting lifestyle change goals and a data set related to patient's social risk and experience. Healthy Together participants have varying levels of comfort and experience with technology. For some, tracking their weight, physical activity minutes, and food intake using pen and paper rather than through technology is simpler..

Sustainability planning took place during the Evaluate phase to identify the program elements that worked well and to consider how those elements could be sustained or improved in future work – at the health center, the Hub, and the national levela. A key aspect of Healthy Together was the centralized model where the PCA/HCCN Hub provided administrative and data reporting support. This Hub model proved effective and beneficial for health centers and, in the future, may be expanded to include responsibility for:

- Completing the CDC's Diabetes Prevention Recognition Program (DPRP) Application

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- Submitting DPRP data
- Organizing Lifestyle Coach training opportunities
- Identifying eligible patients through risk stratification
- Providing program technical assistance to health centers

Health centers with existing organizational priorities for diabetes prevention and management or population health that align with a lifestyle coaching program may identify opportunities to coordinate efforts. For example, while the CDC's National DPP model is focused only on patients with pre-diabetes, the Healthy Together model combines patients with diabetes and patients with pre-diabetes into a single cohort for lifestyle change. Health centers could also consider extending participation to patients with another chronic condition, such as hypertension, who could similarly benefit from lifestyle coaching. The successful launch of Healthy Together represents a significant investment of time, commitment, and collaboration on the part of national, state/regional, and local partners. The initiative offers a new and innovative approach to diabetes prevention and control that can inform CDC's NDPP model and can be scaled within health centers nationally.

Notably, there was a level of camaraderie and support that developed between the Lifestyle Coaches and the participants, as well as between the participants, with benefits that extend beyond clinical outcomes to social connections and a sense of well-being. NACHC, and all the Healthy Together project partners, look forward to the sharing and adoption of this program in other health centers across the country, made possible by the tools and resources created through this pilot project.

REFERENCES:

1. Health Resources and Services Administration. National Health Center Program Uniform Data System (UDS) Awardee Data. https://data.hrsa.gov/tools/data-reporting/program-data/national

2. Centers for Disease Control and Prevention. (2023, April 25). About Prediabetes and Type 2 Diabetes. https://www.cdc.gov/diabetes/prevention/about-prediabetes.html

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